

Cookwell Referral Form

Personal Details

Name

Address

Postcode

D.O.B Age

Telephone Home Telephone Mobile

Email

Gender **M / F / TS** (please circle)

Ethnicity (see National codes)

Disability **Yes / No** (please circle) If Yes please give details

Food Allergy **Yes / No** (please circle) If Yes please give details

When would you prefer to attend Cookwell: Weekdays Weekends Evenings

Where did you hear about his programme?

Referrer's Details (N/A for Self referrals)

Name and Profession

Surgery / Department

Address

Postcode

Telephone

Date of referral (DD/MM/YY)

Eligibility Criteria

All participants must fulfil the following criteria before being referred to a Cookwell Programme

Please tick:

Age 16+

Works, lives or has GP in Sandwell

Contra-indications

Participants diagnosed with any of the following contra-indications are not eligible to participate in the Cookwell Programme

Type I Diabetics

Type II diabetic patients taking insulin injections

Type II diabetics taking Gliclazide, Glibenclamide, or Glimepiride

Type II diabetic patients on Narglinide or Repaglinide

Type II diabetic patients on Exenatide (Byetta)